STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085012	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY HEALTHCARE & REHAB CENTER	801 N. BROOM STREET WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced annual and complaint survey was conducted at this facility from September 12, 2017 through September 21, 2017. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census the first day of the survey was 89. The Stage 2 survey sample size was 33. Abbreviations/definitions used in this report are as follows: ABT/abt- antibiotic; AD _ Activities Director; ADL - Activities of Daily Living; ADON - Assistant Director of Nursing; BM (bm)- bowel movement; CNA - Certified Nurse's Aide; COTA - Certified Occupational Therapy Assistant; DOH - Director of Housekeeping; DON - Director of Nursing; ED - Emergency Department; SW-social worker/social service; e.g. - for example; eMAR/MAR - electronic Medication Administration Record/Medication Administration Record; ESRD - End Stage Renal Disease/the last stage (stage five) of chronic kidney disease. When kidney diseases develop into ESRD, dialysis or a kidney transplant is necessary to live; FMD - Facility Maintenance Director; FSD - Food Service Director; H & P - History and Physical; IDT- interdisciplinary team; LPN - Licensed Practical Nurse; TAR- treatment administration record:	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 10/19/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 MDS - Minimum Data Set/standardized assessment tool used in Long Term Care facilities; MG (mg)- milligrams; ML (ml)- milliliters; MRR- Medication Regimen Review/monthly review of residents medications to find any irregularities or findings inconsistent with usual, proper, accepted, or right approaches to providing pharmaceutical services or that impede or interfere with achieving the intended outcomes of those services; NHA - Nursing Home Administrator; NP- Nurse Practitioner; OOB - out of bed; OT - Occupational Therapy/Therapist; PNA- pneumonia; Pt/pt - patient; PO/po - by mouth; post-after; prn-as needed; RN - Registered Nurse; SSI - Sliding Scale Insulin/a dosing schedule based on a particular blood sugar value or range of values. The insulin dose to be administered becomes greater when blood sugar readings are higher; ST - Speech Therapy/Therapist; U - Unit/dosage measurements for insulin; UM - Unit Manager; 1:1-one to one; Abscess - accumulation of pus OR a cavity filled with pus that can develop anywhere; Accu-Chek - blood fingerstick testing for blood sugar levels; Acute - sudden onset; Adverse reactions- side effects: Aspiration - food enters airway and lungs; Convulsions - a sudden, violent, irregular	F 000		

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F 000	Continued From page 2 movement of a limb or of the body, caused by involuntary contraction of muscles and associated especially with brain disorders such as epilepsy (seizure disorder), the presence of certain toxins or other agents in the blood, or fever in children.; Diabetes Mellitus - elevated blood sugar levels; Extensive assist - resident involved in activity, staff provide weight-bearing support; Fluid restriction - a fluid restricted diet limits the amount of fluid that you consume each day. In addition to beverages, many foods provide fluids. Examples include ice cream, yogurt, gelatin, pudding, soups, sauces, and watery fruits; Hemi sling - a sling that is a positioning device for the flaccid upper extremity (body part hanging loosely or limply); Hemodialysis/dialysis - in hemodialysis, a dialysis machine and a special filter called an artificial kidney, or a dialyzer, are used to clean your blood of waste products which the kidneys are no longer capable of doing; Hypoglycemia - dangerously low blood sugar level; Humulin R insulin - injectable medication used to control blood sugar levels that begins to work approximately 30 minutes after administration; Subluxation - an incomplete or partial dislocation of a joint.	F 000		
F 225 SS=D	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or	F 225		11/1/17

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F 225	Continued From page 3 mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.	F 225		

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F 225	Continued From page 4 (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility lacked thorough investigations for incidents that had the potential for abuse for one (R13) out of 33 Stage 2 sampled residents . Additionally, the facility failed to report to the State Agency two (2) incidents of alleged abuse . Findings include: Review of R13's clinical record, review of facility documentation, and resident and staff interviews revealed: A. The Resident/Family Grievance Concern Form, dated 1/30/17, stated, "...Grievance Summary Statement: (resident's name) is alleging that a CNA hit her in her face with her purse (resident's purse)...Steps Taken in Investigation;...The resident was interviewed by our DON (E2) as well as this worker (E4/SW)...". The Grievance Form stated that the accused CNA was also interviewed. The facility stated under Summary of Pertinent	F 225	A. R13's allegations will be thoroughly investigated treated as potential abuse. B. R13 allegations will be reported to the state agency per guidelines. C. Staff will be in-serviced on reporting criteria for all residents. D. The NHA/DON/Designee will audit all grievances along with allegations to ensure whether or not they meet the abuse reporting criteria. This will be done daily X's 5 days a week with the expectation of 100% compliance. Once we have achieved daily compliance, we will audit the grievances and allegations weekly with the expectation of 100% compliance. Once this is achieved, we will audit the grievances and allegations monthly until we have achieved 100% compliance. Once we have achieved 3	

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F 225	Continued From page 5 Findings/Conclusions: "...the grievance was not confirmed. (Resident name) appears to be falsely accusing staff...". Review of R13's clinical record lacked evidence of a progress note for the alleged incident from 1/30/17. On 9/12/17 at 2:39 PM, during a Stage 1 resident interview, R13 stated that a CNA threw the resident's heavy pocketbook on her face when the resident was lying in bed and bent her eyeglasses. R13 stated that the eyeglasses do not fit correctly now and slide down her face. On 9/14/17 at 2:48 PM, during an interview, R13 again recounted the incident of a CNA throwing a pocketbook at her. During an interview on 9/18/17 at 10:40 AM, E4 (Social Services) stated that any resident allegations are treated as a grievance unless they are confirmed by the facility's investigation first. E4 further stated that when the facility substantiates an allegation, that is when the State Agency is notified. The facility failed to have any written statements from the alleged CNA or any potential witness statements regarding this incident. The facility failed to identify this incident had the potential for abuse and failed to report it to the State Agency as per facility policy. B. Review of the Resident/Family Grievance Concern Form, dated 2/27/17, stated under the heading: Grievance Summary Statement: "(Resident's name) reports that her aid threw her cell phone at her chest. The resident also reports	F 225	consecutive months worth of 100% compliance, we will conclude that we have successfully addressed the deficient practice. Compliance rates will be reported at our QAPI meetings. A. R13's allegations will be thoroughly investigated treated as potential abuse. B. R13's allegations will be treated as potential abuse and reported to the state agency. C. Staff will be in-serviced on reporting criteria for all residents. D. The NHA/DON/Designee will audit all grievances along with allegations to ensure whether or not they meet the abuse reporting criteria. This will be done daily X's 5 days a week with the expectation of 100% compliance. Once we have achieved daily compliance, we will audit the grievances and allegations weekly with the expectation of 100% compliance. Once this is achieved, we will audit the grievances and allegations monthly until we have achieved 100% compliance. Once we have achieved 3 consecutive months worth of 100% compliance, we will conclude that we have successfully addressed the deficient practice. Compliance rates will be reported at our QAPI meetings. A. R13 has had all of her concerns and/or grievances properly documented and	

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F 225	Continued From page 6 that her roommate put her hands between her legs in an inappropriate way." Review of the grievance form revealed the lack of the second page There is no second page of the Resident/Family Grievance Concern Form provided by the facility. This page identified steps the facility completed during the investigation and the determined results. The grievance form did include written statements from E10 (LPN), E11 (CNA), E12 (CNA), and E13 (CNA). A nurse's progress note, dated 2/27/17, stated, "Resident had allegations of CNA hitting her in chest with cellphone and her roommate putting her hands between her legs." During an interview on 9/18/17 at 10:40 AM, E4 (Social Services) stated that any resident allegations are treated as a grievance unless they are confirmed by the facility's investigation first. E4 further stated that when the facility substantiates an allegation, that is when the State Agency is notified. The facility failed to identify this incident had the potential for abuse and failed to report it to the State Agency as per facility policy. Findings were reviewed with E2 (DON) on 9/20/17 at 3:45 PM. On 9/21/17 at approximately 7:00 PM findings were reviewed with E1 (NHA) and E2 during the exit conference.	F 225	submitted to the stage agency since survey. B. Resident charts with abuse allegations were audited to ensure a progress note was written. C. Nursing staff will be in-serviced on writing a progress note when an abuse allegation is made. D. The NHA/DON/Designee will audit all grievances along with allegations to ensure that a progress note is written if the grievance is reported as an abuse allegation. This will be done daily X's 5 days a week with the expectation of 100% compliance. Once we have achieved daily compliance, we will audit the grievances and allegations weekly with the expectation of 100% compliance. Once this is achieved, we will audit the grievances and allegations monthly until we have achieved 100% compliance. Once we have achieved 3 consecutive months worth of 100% compliance, we will conclude that we have successfully addressed the deficient practice. Compliance rates will be reported at our QAPI meetings. A. R13 has had all of her concerns and/or grievances properly documented and submitted to the state agency since survey. B. Resident grievances were audited to ensure statements were obtained.	

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F 225	Continued From page 7	F 225	C. SSD will be in-serviced on the grievance procedure and abuse reporting. D. The NHA/DON/Designee will audit all grievances along with allegations to ensure that statements are obtained as part of the grievance process as appropriate. This will be done daily X's 5 days a week with the expectation of 100% compliance. Once we have achieved daily compliance, we will audit the grievances and allegations weekly with the expectation of 100% compliance. Once this is achieved, we will audit the grievances and allegations monthly until we have achieved 100% compliance. Once we have achieved 3 consecutive months worth of 100% compliance, we will conclude that we have successfully addressed the deficient practice. Compliance rates will be reported at our QAPI meetings.	
F 226 SS=D	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph	F 226		11/1/17

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F 226	Continued From page 8 §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of facility documentation, it was determined that for 1 (R13) out of 33 Stage 2 sampled residents the facility failed to implement their written policies and procedures for Abuse Reporting and Investigation and Incident and Accident Reports. The facility failed to immediately report two allegations of physical abuse between R13 and facility staff to the State Agency on 1/30/17 and 2/27/17; failed to utilize the facility's Incident Reports when allegations of abuse are reported; and failed to protect R13 by immediately removing E12 (CNA), the alleged perpetrator, from duty pending investigation. Findings include: Cross Refer F225 The facility policy titled, Abuse Reporting and	F 226	A. Statements were not obtained during the grievance process concerning R13's allegation of having a pocketbook thrown at her. We are unable to go back and obtain these statements as this allegation was made in January and February of this year. B. During the investigative process of both abuse and/or grievances, statements will be obtained through the course of the investigation as applicable. C. Social Services will be in-serviced on the proper procedure for investigating a grievance, including obtaining statements. All staff will be in-serviced on providing statements whenever an abuse allegation	

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F 226	Continued From page 9 Investigation, last revised in 2016, stated, "...in the case of alleged or suspected abuse...the following will apply to both alleged and suspected abuse. If an employee is involved in the suspected violation, the employee will be immediately removed from duty. All reports of alleged or suspected abuse must be reported to the Administrator immediately as well as to the resident's family and physician. The Department of Health will be immediately notified of the alleged event..." The facility policy titled Incident and Accident Reports, last revised in 2016, stated, "The following occurrences warrant an incident report: a. Actual, Alleged or suspected abuse..." The facility policy titled Incident Form and Review, last revised in 2016, stated, "State and local agencies will be notified as stated in Abuse Reporting and Investigation policy." Review of R13's clinical record revealed the following: 1/30/17 - The facility's Resident/Family Grievance Concern Form stated, "R13 is alleging that a CNA hit her in the face with her purse". The facility failed to utilize an Incident Report as per their policy when an allegation of abuse was reported. 2/27/17 - The facility's Resident/Family Grievance Concern Form stated, "(R13) reports that her aide (CNA) threw her cell phone at her chest. (R13) also reports that her roommate put her hands between her legs in an inappropriate way." The facility failed to utilize an Incident Report as per their policy when an allegation of abuse was reported.	F 226	is made and/or a grievance is filed as applicable. Nursing will be in-serviced on writing progress notes and completing incident reports for abuse allegations. D. The NHA/DON/Designee will audit each grievance to ensure that the necessary statements are obtained. This will also include abuse investigations. NHA/DON/Designee will also audit to ensure a progress note is written and an incident report is completed for all abuse allegations. The audit will be completed daily until 3 consecutive 100% compliance is achieved, weekly until 3 consecutive 100% compliance is achieved and monthly until 3 consecutive 100% compliance is achieved. Once we have achieved 3 consecutive months worth of 100% compliance, we will conclude that we have successfully addressed the deficient practice. Compliance rates will be reported in our QAPI meetings. A. Statements were not obtained during the grievance process concerning R13's allegation of having a cell phone thrown at her. We are unable to go back and obtain this statement as this allegation was made in January and February of this year. B. During the investigative process of both abuse and/or grievances, statements will be obtained through the course of the investigation as applicable. C. Social Services will be in-serviced on the proper procedure for investigating a	

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F 226	Continued From page 10 2/27/17 - In the facility's form entitled, Reportable Statement, E10 (LPN) stated, "...(E12 - CNA) reported to me that (R13) was complaining that she threw her cell phone to her and it hit her chest ...This writer and (E12) went to the room (R13's room) and (R13) said (E12) dropped her cell phone on her chest ...". The facility failed to protect R13 after an allegation of abuse when E10 went to R13's room with E12, the alleged perpetrator, to question R13 about her allegation. The facility failed to implement their Abuse Reporting and Investigation policy. The facility failed to immediately report these two allegations of physical abuse on 1/30/17 and 2/27/17. from R13 to the State Agency. On 9/18/17 at 10:40 AM, E4 (SS) was interviewed. E4 stated an allegation of abuse is treated as a grievance unless it is confirmed. After the facility investigates and confirms the allegation, it is then reported to the State Agency. This statement demonstrates that E4 is unaware of the facility's Abuse Reporting and Investigation policy and procedure. Findings were reviewed with E2 (DON) on 9/18/17 at 3:45 PM. The facility failed to immediately report two allegations of physical abuse to the State Agency on 1/30/17 and 2/27/17; failed to utilize the facility's Incident Reports policy when allegations of abuse are reported; and failed to protect R13 by immediately removing E12 (CNA), the alleged perpetrator, from duty.	F 226	grievance, including obtaining statements. All staff will be in-serviced on providing statements whenever an abuse allegation is made and/or a grievance is filed as applicable. Nursing will be in-serviced on writing progress notes and completing incident reports for abuse allegations. D. The NHA/DON/Designee will audit each grievance to ensure that the necessary statements are obtained. This will also include abuse investigations. NHA/DON/Designee will also audit to ensure a progress note is written and an incident report is completed for all abuse allegations. The audit will be completed daily until 3 consecutive 100% compliance is achieved, weekly until 3 consecutive 100% compliance is achieved and monthly until 3 consecutive 100% compliance is achieved. Once we have achieved 3 consecutive months worth of 100% compliance, we will conclude that we have successfully addressed the deficient practice. Compliance rates will be reported in our QAPI meetings	
F 241 SS=D	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY	F 241		11/1/17

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F 241	Continued From page 11 (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on observation, it was determined that the facility failed to promote the maintenance or enhancement of residents quality of life recognizing each resident's individuality. The facility additionally failed to protect the rights of R40 when a staff member loudly stated private information about R40, which included usage of R40's name while using a derogatory term in the 2nd floor lounge area in front of the nurses station while multiple residents were eating and/or being fed. Findings include: During dining observations on the 2nd floor on 9/12/17 at 12:25 PM, E9 (LPN) stood in the middle of the lounge in front of the nurses station and stated loudly, "Is R40 (name of resident used) still a feeder?" Use of the term "feeder" implies that a resident has to be fed and is unable to eat on their own. There were several residents eating in the lounge requiring variable levels of assistance to eat, including some that were being fed, 4-5 staff members and 2 state surveyors. The statement was derogatory and E9 failed to protect private information about R40 who was in his room. Additionally, the statement could be perceived as derogatory and undignified by the residents in the lounge, as well as those within hearing distance in their rooms. Findings were reviewed with E1 (NHA) and E2	F 241	A. R40 was not negatively impacted by this deficient practice. Care Plan updated to reflect extensive staff participation to eat. Staff will refer to the care plan. Employee E9 was re-educated regarding dignity and confidentiality. B. Residents who need assistance with feeding are at risk for this deficient practice. C. Staff will be in-serviced on dignity, respect and confidentiality. D. DON/designee will audit during meal times daily X 5 days per week until three consecutive 100% compliance is achieved, weekly until three consecutive 100% compliance is achieved, monthly until three consecutive 100% compliance is achieved. Once we have achieved 3 months worth of 100% compliance, we will conclude that we have successfully addressed the deficient practice. Compliance rates will be reported in our QAPI meetings.	

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F 241	Continued From page 12 (DON) on 9/21/17 at approximately 7:30 PM during the exit conference.	F 241		
F 248 SS=D	483.24(c)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES (c) Activities. (1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and interviews, it was determined that the facility failed to provide an ongoing activity program based on their identified interests, and based on the comprehensive assessment and care plan for one (R63) out of 33 Stage 2 sampled residents. Findings include: Review of R63's clinical record revealed: 10/4/16 - A care plan for activities was developed and was last revised on 6/21/17. The care plan included the goal to participate in independent or group activities of choice when willing and able until next review. Interventions include: A cd player was provided in R63's room for music enjoyment to be turned on during friendly visits; escort to activities of interest such as sports,happy hour,and outdoors; provide	F 248	A. Activities staff has continued to invite R63 to activities of his liking and document attendance. All residents will be invited to attend their activity of liking based upon their assessment and preferences. B. Residents who refuse to participate in activities are at risk for this deficient practice. C. Activities staff in-serviced on 10/17/17 on importance of inviting residents to activities of their liking as well as documenting attendance and/or refusals in order to enhance the residents highest practicable level of physical, mental and psychosocial well-being.	11/1/17

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F 248	Continued From page 13 assistance when needed; provide daily meet and greet; provide friendly visits; provide monthly calendar and go over up-coming events. 10/7/16 - The annual MDS assessment, stated that listening to music, doing things with groups of people, going outside to get fresh air, and participating in religious services, were activities R63 considered to be very important. 10/7/16 - The annual MDS stated R63 needed extensive assistance for locomotion on and off the unit. 4/3/17 - A quarterly Activity Assessment stated that listening to music, doing things with groups of people, going outside to get fresh air, and participating in religious services, were activities R63 considered to be very important. 4/3/17 - A progress note written by E23 (AD), stated that R63 "enjoys watching baseball, basketball, listening to Motown music and jazz, and watching TV westerns...Activity staff will monitor his interests and transport him to programs of his interest." 6/21/17 - An activity progress note stated "...likes to go on the patio, happy hour, and special events." The activity department will continue to invite R63 to activities of his choice. 6/21/17 - A quarterly MDS assessment stated R63 required extensive assist of one staff for locomotion on and off the unit. Review of the facility's June 2017 Activity Calendar revealed there were 20 opportunities for activities that were part of R63's care plan. The	F 248	D. Activities Director/designee will audit 20 activity logs daily X 5 days per week until three consecutive 100% compliance is achieved, weekly until three consecutive 100% compliance is achieved, monthly until three consecutive 100% compliance is achieved. Once we have achieved 3 months worth of 100% compliance, we will conclude that we have successfully addressed the deficient practice. Compliance rates will be reported in our QAPI meetings.	

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F 248	Continued From page 14 June 2017 Activity Log for R63 revealed that R63 was not marked as participating in any of those 20 opportunities: R63 was marked 'napping' on one date. There is no evidence that R63 was invited to and/or refused to attend those activities. Review of the facility's July 2017 Activity Calendar revealed there were 8 opportunities for activities that were part of R63's care plan. The July 2017 Activity Log for R63 revealed that R63 was not marked as participating in any of those 8 opportunities. There is no evidence that R63 was invited to and/or refused to attend those activities. Review of the facility's August 2017 Activity Calendar revealed there were 9 opportunities for activities that were part of R63's care plan. The August 2017 Activity Log for R63 revealed that R63 was not marked as participating in any of those 9 opportunities. There is no evidence that R63 was invited to and/or refused to attend those activities. The following observations were made of R63: 9/12/17 at 10:40 AM - R63 was observed sitting in his room in a wheelchair, not engaged in any activity; 9/12/17 at 2:30 PM - R63 was observed sitting in his room in a wheelchair, not engaged in any activity; 9/13/17 at 9:44 AM - R63 was observed sitting in a wheelchair in the common area around the nurses station, not engaged in any activity; 9/13/17 at 3:40 PM - R63 wheeled his wheelchair to the nurses station where he stayed approximately 10 minutes, then wheeled himself back to his room; 9/14/17 at 10:00 AM - R63 was observed sleeping in his wheelchair in the hallway near the	F 248		

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F 248	Continued From page 15 nurses station; 9/14/17 at 2:40 PM - R63 was observed sleeping in his wheelchair in his room; 9/14/17 at 2:54 PM - R63 was observed in his wheelchair near the nurses desk while an activity was taking place in the common area. R63 was not participating in the activity. 9/18/17 at 9:31 AM - R63 was observed sitting in his room in a wheelchair, not engaged in any activity; 9/20/17 at 11:10 AM - R63 was observed sitting in his wheelchair in the common area with headphones on; and 9/20/17 at 2:50 PM - R63 was observed sleeping in his wheelchair in the common area with headphones on. During an interview with E23 on 9/21/17 at 9:57 AM, the surveyor questioned why R63 was not being taken to activities off of the floor where he resides. E23 stated R63 refuses sometimes, but was not able to provide documentation. The facility failed to involve the resident in an ongoing program of activities that was designed to appeal to his interests and to enhance the resident's highest practicable level of physical, mental, and psychosocial well-being. Findings were reviewed with E2 (DON) on 9/21/17 at 11:35 AM.	F 248		
F 253 SS=E	483.10(i)(2) HOUSEKEEPING & MAINTENANCE SERVICES (i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; This REQUIREMENT is not met as evidenced	F 253		11/1/17

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F 253	Continued From page 16 by: Based on observations and interviews, it was determined that the facility failed to maintain a sanitary, orderly and comfortable interior. Findings include: On 9/12/17 at approximately 11:30 AM, a surveyor observed 19 stationary chairs with arm rests in disrepair in the first floor main dining room. During an environmental tour on 9/19/17 at 3:02 PM, the finding was again observed and confirmed with E7 (FMD) and E8 (DOH). The facility failed to maintain 19 stationary chairs in the first floor main dining room. Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 9/21/17 at 7:30 PM.	F 253	A. 25 sets of new armrests were immediately ordered. Chairs will have armrests installed as soon as they arrive. B. All residents are at risk for this deficient practice. C. The Housekeeping Director will measure each table for the proper height and mark the table stand indicating where the table height should be. Activities and dietary staff will be in-serviced to ensure tables are put back at proper height following an event in the dining room. D. Housekeeping Director/designee will audit the tables daily X 5 days per week until three consecutive 100% compliance is achieved, weekly until three consecutive 100% compliance is achieved, monthly until three consecutive 100% compliance is achieved. Once we have achieved 3 months worth of 100% compliance, we will conclude that we have successfully addressed the deficient practice. Compliance rates will be reported in our QAPI meetings.	
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to	F 280		11/1/17

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F 280	Continued From page 17 be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment.	F 280		

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F 280	Continued From page 18 (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to revise the care plan for one (R116) out of 33 Stage 2 sampled residents. Findings include: Cross refer, F309 example #2A 2A. Review of R116's clinical record revealed the	F 280	A. Care plan for R116 was immediately updated as appropriate. The CNA kardex and tasks were also updated to reflect the ST guidelines for R116. B. During clinical meeting, a report is run for all residents showing new orders and	

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F 280	Continued From page 19 following: 7/31/17 - R116 was admitted to the facility with diagnoses that included stroke with dominant right sided paralysis, difficulty swallowing (dysphagia) and aphasia, a disorder caused by damage to the parts of the brain that control language that can make it hard for you to read, write, and speak. 8/1/17 - A care plan for ADL self care deficit was developed. Interventions included for R116 to be out of bed at a 90 degree angle at all meals, speech evaluation and treatment as needed, and extensive staff participation to eat. 8/21/17 - R116 was readmitted to the facility. The clinical record revealed that R116 started ST services on the day of readmission. 9/6/17 - Review of R116's Order Summary Report revealed an order that stated,"Regular (House Diet) diet Mechanical Soft texture, Nectar consistency, No: peas, corn, spaghetti, rice, drain all fruit or provide applesauce/pudding) Strict 1:1 supervision with all meals, to ensure safe rate, amount and oral clearance post meals, cyclic ingestion 2:1 (nectars)." 9/6/17 - A Diet Requisition Form stated R116 had a diet change and was to receive mechanical soft, nectar thick liquids with no rice, corn, peas, spaghetti. Under comments was written, "Strict 1:1 supervision at all meals ensure: slow rate, amount (small bites) oral clearance." 9/11/17 - A physician's order stated to discontinue ST services "Patient max potential reached at this time, risks of aspiration persist, continue full	F 280	ensuring they are properly entered into the EMR system. If the are not correct, they are immediately updated during the clinical meeting. C. The rehab department will be in-serviced on proper communication to nursing. Rehab will no longer put orders/guidelines into the EMR system. A communication form will be completed by rehab and given to nursing for proper follow up. Nursing will be in-serviced on following up on the communication form received from rehab. D. DON/designee will audit the communication forms and orders daily X 5 days per week until three consecutive 100% compliance is achieved, weekly until three consecutive 100% compliance is achieved, monthly until three consecutive 100% compliance is achieved. Once we have achieved 3 months worth of 100% compliance, we will conclude that we have successfully addressed the deficient practice. Compliance rates will be reported in our QAPI meetings.	

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F 280	Continued From page 20 feeding assist per guidelines, Mechanical soft/Nectars...". Review of R116's hard copy chart revealed a "Feeding Guideline," dated 9/6/17. The guideline stated, "Diet: Mechanical soft/Nectars, Out of bed for all meals, Strict 1:1 feeding assist with all meals, Ensure: small bites, slow rate of intake, cyclic ingestion (alternate food:liquids) 2:1 (ensure oral clearance prior to adding more solids or liquids), ensure oral clearance between bites and post meal, maintain upright seated position during and 30-45 minutes post meals." The facility failed to revise R116's care plan to reflect these specific feeding guidelines. Findings were reviewed with E2 (DON) on 9/21/17 at approximately 11:30 AM.	F 280		
F 309 SS=E	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in	F 309		11/1/17

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F 309	Continued From page 21 accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and interviews, it was determined that the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care for three (R16, R58 and R116) out of 33 Stage 2 sampled residents. The facility failed to accurately monitor fluid intakes for R58, who was on fluid restriction. For R116, the facility failed to apply a right arm sling when out of bed and failed to provide 1:1 supervision during all meals. For R16, the facility failed to implement and/or follow the bowel protocol ordered by the physician on 2 occasions from 8/23/17 to 9/20/17. Findings include: The facility policy for Chart Check: Twenty-Four Hour Guidelines, revised 2016, stated, "...When	F 309	A. Resident R58, the CNA task list was immediately updated to reflect the proper amount of fluid to be administered to meet the physician ordered fluid restriction. B. Residents on fluid restriction were reviewed for accuracy. There were no additional inaccurate fluid restrictions. C. Resident R58, the nurse who put the order into the MAR for the nursing portion of the fluid restriction failed to carry this over to the CNA task list. Nurse was re-educated regarding how to properly manage this process. D. DON/designee will audit the residents on a fluid restriction daily X 5 days per week until three consecutive 100%	

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F 309	Continued From page 22 there is a new order on the physician's order sheet, the nurse will perform the following: a. Check the MAR, TAR, unit calendar to assure accurate transcription b. Check for the presence of the prescribed medication, treatment product, assistive device, etc. c. Initiate measures to correct any orders that have not been commenced." 1. Review of R58's clinical record revealed the following: R58 was originally admitted to the facility in 2012 and had diagnoses that included ESRD requiring hemodialysis. 9/1/14 - A care plan for the problem potential for alteration in nutrition and hydration was developed and last revised on 7/28/17 and stated that R58 was on fluid restriction per dialysis recommendation. Interventions included to provide diet as ordered, maintain fluid restriction as ordered, encourage fluids up to 1500 ml daily, and monitor PO intakes and record. 1/26/17 - A physician's order stated that R58 was on a 1500 ml fluid restriction per 24 hours. The allotment of fluid amounts were as follows: - Dietary allotment equaled a total of 600 mls per 24 hours, divide among the three (3) meals; - Nursing allotment equaled a total of 900 mls divided between the three (3) shifts (11 PM- 7 AM; 7 AM - 3 PM; 3 PM - 11 PM). 6/1/17 through 9/17/17 - The CNA Documentation Survey Reports were reviewed and lacked evidence of any fluid intake monitoring for meals. Although the facility was documenting percentages of amounts eaten, they were not	F 309	compliance is achieved, weekly until three consecutive 100% compliance is achieved, monthly until three consecutive 100% compliance is achieved. Once we have achieved 3 months worth of 100% compliance, we will conclude that we have successfully addressed the deficient practice. Compliance rates will be reported in our QAPI meetings. A. Resident R116, the OT was applying the sling daily. The CNA task list was updated to reflect applying the sling when R116 was out of bed. B. Residents who utilize a sling have had their task list updated. C. Therapy will no longer put orders into our EMR system. Therapy will complete a communication form and give it to nursing to review with the physician and enter the order, if received from the physician. D. DON/designee will audit the rehab communication forms and orders, the list of residents on the bowel protocol and the residents on a fluid restriction daily X 5 days per week until three consecutive 100% compliance is achieved, weekly until three consecutive 100% compliance is achieved, monthly until three consecutive 100% compliance is achieved. Once we have achieved 3 months worth of 100% compliance, we will conclude that we have successfully addressed the deficient practice. Compliance rates will be reported in our QAPI meetings.	

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F 309	Continued From page 23 indicating how much fluid R58 had consumed. 6/1/17 through 9/17/17 - The eMARs were reviewed and revealed that nursing was documenting the fluid amounts consumed on each shift and then the 11 PM - 7 AM shift was totaling the 24 hour totals. The 24 hour totals were to also include the amounts R58 had consumed at meals. Review of the eMARs revealed that the 24 hour totals were consistently recorded as 1500. It was unclear where the staff totaling the amounts was obtaining the meal totals from, as there was no evidence that this information was documented anywhere. 9/18/17 8:48 AM - During an interview, E21 (CNA) stated that only residents who are on fluid restriction are monitored separately for their fluid intakes and those amounts are separately documented in the electronic record. E21 stated that if a resident is not on fluid restriction, they will record both liquids and solids consumed as one percentage amount under amount eaten. 9/18/17 10:17 AM - During an interview, E9 (LPN) was asked to review R58's fluid restriction totals with this surveyor. E9 confirmed that there were no fluid amounts recorded for meals in the electronic record. E9 also confirmed that it was not possible for the 11 PM - 7 AM shift to consistently be documenting the 24 hour totals as 1500 mls since they had no way of knowing what had been consumed by R58 during the three meals. The facility failed to accurately monitor fluid amounts for R58, who was on a 1500 ml fluid restriction, from 6/1/17 through 9/17/17.	F 309	A. R16 had a bowel movement. B. Residents were reviewed that were on the bowel protocol to ensure we were following our policy. No other residents were indentified. C. Nurse was re-educated on checking the bowel protocol alerts in PCC. Nursing staff will be in-serviced on checking the alerts in PCC and following the bowel protocol. D. DON/designee will audit the list of residents on the bowel protocol daily X5 days per week until three consecutive 100% compliance is achieved, weekly until three consecutive 100% compliance is achieved, monthly until three consecutive 100% compliance is achieved. Once we have achieved 3 months worth of 100% compliance, we will conclude that we have successfully addressed the deficient practice. Compliance rates will be reported in our QAPI meetings. A. CNA task list updated to reflect R116 to receive strict 1:1 supervision at all meals, ensure slow rate, amount (small bites) oral clearance per ST Feeding Guidelines. B. Residents on Feeding Guidelines were reviewed and their CNA task list was updated accordingly. C. Nursing staff to be in-serviced on	

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F 309	Continued From page 24 9/21/17 11:30 AM - Findings were reviewed with E2 (DON). On 9/21/17 at approximately 7:00 PM, findings were reviewed with E1 (NHA) and E2. 2A. Review of R116's clinical record revealed the following: 7/31/17 - R116 was admitted to the facility with diagnoses that included stroke with dominant right sided paralysis, difficulty swallowing (dysphagia) and aphasia, a disorder caused by damage to the parts of the brain that control language that can make it hard for you to read, write, and speak. 8/1/17 - A care plan for ADL self care deficit was developed. Interventions included for R116 to be out of bed at a 90 degree angle at all meals, speech evaluation and treatment as needed, and extensive staff participation to eat. 8/7/17 - The admission MDS assessment stated R116 had no speech but was usually able to make himself understood and was usually able to understand others. The MDS stated R116 required extensive assist of two (2) staff for bed mobility, transfers to and from bed, and extensive assist of one (1) staff for eating. Review of R116's clinical record revealed that his oral intakes were inadequate and despite measures implemented by the facility he continued with inadequate oral intake. On 8/15/17, when laboratory blood tests revealed abnormal values, R116 was sent out to the ED for evaluation and treatment and was subsequently hospitalized.	F 309	following Feeding Guidelines. Therapy no longer enters orders into PCC. New orders are reviewed during clinical meeting. D. DON/designee will audit the feeding guidelines orders daily X 5 days per week until three consecutive 100% compliance is achieved, weekly until three consecutive 100% compliance is achieved, monthly until three consecutive 100% compliance is achieved. Once we have achieved 3 months worth of 100% compliance, we will conclude that we have successfully addressed the deficient practice. Compliance rates will be reported in our QAPI meetings.	

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F 309	Continued From page 25 8/17/17 - R116 had a swallowing evaluation completed while hospitalized. Post testing recommendations stated, "Recommendations: 1. Dysphagia 1 (pureed foods)/nectar thick liquids with direct supervision/assistance (encourage pt to self feed) 2. Choking precautions 3. Allow extra time to swallow, alternate liquids and solid, check mouth after meals for oral residuals (unswallowed food) 4. Allow ice chips apart from meals after good mouth care. ST f/u (follow up), suspect can advance diet texture...". 8/21/17 - The hospital discharge summary stated, "...There were also discussions regarding patient's poor oral intake. He was eventually started on a dysphagia 1/nectar thickened diet which he tolerated well. He was also told to avoid thin liquids and choking precautions were recommended as well as small self-feeds with close supervision...". 8/21/17 - R116 was readmitted to the facility. The clinical record revealed that R116 started ST services on the day of readmission. 9/6/17 - Review of R116's Order Summary Report revealed an order that stated, "Regular (House Diet) diet Mechanical Soft texture, Nectar consistency, No: peas, corn, spaghetti, rice, drain all fruit or provide applesauce/pudding) Strict 1:1 supervision with all meals, to ensure safe rate, amount and oral clearance post meals, cyclic ingestion 2:1 (nectars)." 9/6/17 - A Diet Requisition Form stated R116 had a diet change and was to receive mechanical soft, nectar thick liquids with no rice, corn, peas, spaghetti. Under comments was written, "Strict	F 309		

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F 309	Continued From page 26 1:1 supervision at all meals ensure: slow rate, amount (small bites) oral clearance." 9/11/17 - The ST Discharge Summary stated, "...seen for few sessions since prior update, Patient tolerating mech (mechanical) soft, continues with increased rate and amount intake requiring max (maximum) assist to slow down, small bites, utilize cyclic ingestion to improve oral control and clearance with solids/nectars...Patient with continued poor PO...met with family and IDT regarding continued risks of aspiration...patient and wife agreed to soft diet/nectars with 1:1 assist with meals to ensure safety with intake/minimize aspiration risks...Patient optimal on soft (NO peas, rice, corn, spaghetti, fruit in juice, salad) 1:1 assist required to minimize risks of aspiration (guidelines in medical chart and posted in room)...Discharge Plans & Instructions: Patient, caregivers and wife educated at length regarding feeding guidelines given risks of aspiration and need for full assist with PO to minimize risks of aspiration...Handouts posted and provided for swallow safety...". 9/11/17 - A physician's order stated to discontinue ST services "Patient max potential reached at this time, risks of aspiration persist, continue full feeding assist per guidelines, Mechanical soft/Nectars...". Review of R116's hard copy chart revealed a "Feeding Guideline," dated 9/6/17. The guideline stated, "Diet: Mechanical soft/Nectars, Out of bed for all meals, Strict 1:1 feeding assist with all meals, Ensure: small bites, slow rate of intake, cyclic ingestion (alternate food:liquids) 2:1 (ensure oral clearance prior to adding more solids or liquids), ensure oral clearance between bites	F 309		

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F 309	Continued From page 27 and post meal, maintain upright seated position during and 30-45 minutes post meals." The facility failed to revise R116's care plan to reflect these specific feeding guidelines. The following observations were made of R116: 9/14/17 12:46 PM - R116 was seated in a wheelchair in the hallway near the nurse's station feeding himself lunch. Although staff were present in the area, they were busy feeding other residents, collecting finished lunch trays or doing work at the nurse's station. The facility failed to provide R116 with 1:1 supervision during the meal according to his plan of care. 9/18/17 12:20 PM - R116 was seated in a wheelchair in the hallway near the nurse's station feeding himself lunch. Although staff were present in the area, they were busy feeding other residents, distributing other resident's lunch trays or doing work at the nurse's station. After R116 was done eating, he pushed the tray table away and wheeled himself back to his room. The facility failed to provide R116 with 1:1 supervision during the meal according to his plan of care. 9/19/17 8:15 AM - R116 was seated in bed with the head of his bed at 90 degrees feeding himself breakfast with E22 (LPN) present in the room. E22 was called out of R116's room to check on a resident down the hall. E22 returned to R116's room after approximately 5-10 minutes. R116 remained unsupervised eating during this time. 9/19/17 12:22 PM - R116 was seated in a wheelchair in the hall near the nurse's station. At 12:35 PM, lunch was served to R116 and he	F 309		

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F 309	Continued From page 28 began eating. Although staff were present in the area, they were busy feeding other residents, distributing other resident's lunch trays or doing work at the nurse's station. The facility failed to provide R116 with 1:1 supervision during the meal according to his plan of care. R116 pushed his tray table away when he was observed by E23 (ST), who offered him more beverages and sat with him while he drank and ate some thickened soup. 9/21/17 approximately 11:30 AM - Findings were reviewed with E2 (DON). E2 stated that the information regarding the feeding guidelines had not been entered correctly into the electronic record system by the therapy department and thus did not get transferred to the care plan, the eMAR/eTAR or the CNA task history. E2 stated that nursing was not aware. It was pointed out by the surveyor that there was a valid order in R116's clinical record, dated 9/6/17 and signed by the physician on 9/12/17. Additionally, E2 was asked how the facility completed their 24 hour chart checks (a process in which the 11 PM -7 AM shift reviews all orders for the preceding 24 hours in an attempt to identify any errors), that this was not identified? E2 stated that the only way a chart check would have been completed was if therapy printed the order sheet and placed it in the chart. E2 was informed that an order sheet was present in the chart and that it was signed off by the physician. The facility failed to ensure that R116, who was at high risk for aspiration, was provided with 1:1 supervision with meals according to his plan of care. Findings were reviewed with E1 (NHA) and E2	F 309		

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F 309	Continued From page 29 during the exit conference on 9/21/17 at approximately 7:00 PM. 2B. Review of R116's clinical record revealed the following: 9/15/17 - A physician's order was entered that stated, "apply right hemi sling for transfers and when OOB for subluxation." 9/15/16 - An OT Daily Treatment Note stated, "...Educated nursing and CNA in proper donning of...and arm sling for all transfers." 9/18/17 10:40 AM - Observed R116 seated in a wheelchair in the hallway outside his room with no right arm hemi sling in place. E24 (OT) arrived to take resident down for therapy services and was observed applying R116's right arm hemi sling. 9/18/17 - An OT Daily Treatment Note stated, "...Patient sitting OOB in w/c (wheelchair). Patient not wearing hemi sling upon initial session. Therapist applied hemisling for support." 9/19/17 12:22 PM - Observed R116 seated in a wheelchair in the hallway near the nurse's station. R116 had a pillow lying across his lap on the right side but his right arm was not on it, nor was he wearing the right arm hemi sling. 9/19/17 3:20 PM - During an interview, E24 confirmed that an order was written for R116's sling on 9/15/17 and that the sling was at the bedside. E24 confirmed that she had to apply the sling yesterday as he was not wearing it when up in the wheelchair, and that it was at the bedside.	F 309		

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F 309	Continued From page 30 9/19/17 3:55 PM - In a second interview, E24 stated that when new measures, e.g., a sling, are implemented nursing is educated on it's use and it is documented in the therapy notes. E25, a COTA present during the interview with E24, stated he trained two nurses on day shift and evening shift on the sling and wrote it in his therapy note on 9/15/17. Additionally, E24 stated that it would have been brought up in morning meeting on Monday, so that nursing can place it on the CNA Tasks and in the care plan. 9/19/17 - An OT Daily Treatment Note stated, "...CNA and nurse on 3-11 educated on proper technique of donning right hemi sling. Staff educated on purpose of hemi sling. Hemi sling ordered for when patient is out of bed and during functional transfers. Staff educated...". 9/19/17 6:05 PM - Observed R116 transferred into a w/c by 2 staff nurses. R116 was brought out into the hallway for dinner, where E6 (UM) sat with him while he ate. R116 was not wearing the right arm hemi sling. The facility failed to ensure that R116's right arm hemi sling was applied during transfers and while out of bed. On 9/21/17 at approximately 11:30 during an interview, E2 (DON) stated that therapy had not entered the order correctly and it was not transcribed onto the eMAR or CNA Task history so staff was not aware. Findings were reveiwed with E1 (NHA) and E2 during the exit conference on 9/21/17 at approximately 7:00 PM.	F 309		

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F 309	Continued From page 31 3. Review of the clinical record revealed: R16 was admitted to the facility on 8/18/17 with diagnoses including constipation. On 8/18/17, the facility developed a care plan entitled potential for constipation with a goal to have a bm at least every 3rd day through the review date of 9/6/17. Interventions included: monitor for signs and symptoms of complications related to constipation (listed), monitor medication for side effects of constipation, keep physician informed of any problems, and follow bowel protocol for bowel management. Review of R16's admission MDS, dated 8/25/17, coded R16 as having serious mental illness and other related conditions, including psychosis. R16's decisions for daily decision making were poor and she required cues and supervision. On 8/26/17, a physician ordered the following bowel protocol for R16: - Milk of Magnesia (MOM) 30 ml by mouth as needed for bm protocol, give if no bm in 3 days; - Dulcolax insert one suppository rectally as needed for constipation- bowel protocol if no results from MOM within 8 hours; and - Fleet Enema insert one applicatorful rectally as needed for bowel protocol for constipation or no bm from Dulcolax suppository in 8 hours, call MD if no results in 8 hours. The first occurrence of no bm in more than 3 days was as follows (only able to view 30 days of bm's as this is all the electronic system allows): - bm documentation: no bm from 8/23- 8/29/17 for 18 shifts or 6 days;	F 309		

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F 309	Continued From page 32 - August MAR: R16 received a dose of MOM on 8/26/17 at 11 AM that was ineffective and; another dose of MOM on 8/28/17 at 7 AM that was also ineffective. - R16 had a large spontaneous bm on 8/29/17. The facility failed to follow R16's bowel protocol and administer a Dulcolax suppository 8 hours after the 8/26/17 dose was ineffective and follow the bowel protocol as ordered. The second occurrence of no bm in more than 3 days was as follows: - bm documentation: no bm from 9/14- 9/18/17 (12 shifts or 4 days); - September 2017 MAR: no bowel protocol medications given; - R16 had spontaneous bm on 9/18/17 on 3-11 shift. The facility failed to implement R16's bowel protocol as ordered. During an interview on 9/21/17 at 3:26 PM with E2 (DON), findings were reviewed and confirmed by E2. The facility failed to follow physician orders for bowel protocol for R16. R16 had no bm for 18 shifts from 8/23- 8/29/17 and for 12 shifts from 9/14- 9/18/17.	F 309		
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	F 312		11/1/17

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F 312	Continued From page 33 This REQUIREMENT is not met as evidenced by: Based on record review, resident, and staff interviews, it was determined that the facility failed to ensure that one (R13) out of 33 Stage 2 sampled residents, who was unable to carry out activities of daily living, received the necessary services to maintain good hygiene. Findings include: Review of R13's clinical record revealed: The quarterly MDS assessment, dated 6/21/17, stated that R13 was totally dependent and required two (2) person assistance for bathing. Review of R13's orders showed a physician's order for showers twice a week. Review of the CNA Assignment sheet, dated 9/18/17 for the 3 PM - 11 PM shift, revealed R13 was not on the list to receive a shower that day. On 9/19/17 at 10:44 AM, during an interview, R13 stated she gets a shower every Monday and Thursday, but she did not get her shower last night (Monday). R13 stated she asked E14 (R13's assigned CNA for 3:00 PM -11:00 PM shift) about her shower and he informed her that she was " not on the list". R13 stated she asked the 3:00 PM-11:00 PM nurse, E19 (LPN) about getting a shower, and that nurse stated, "You're not on the list". On 9/19/17 at 3:16 PM, during an interview with E14 (CNA), he stated he did not give E13 a shower on her regularly scheduled shower night because she was not on the shower list. E14 stated the shower list was compiled by E6 (Unit	F 312	A. Resident R13 was given a shower and has received a shower per her plan of care since survey completion. B. Shower schedules were reviewed for residents and placed in the CNA task list meeting each residents preference. C. Unit Manager has been re-educated regarding properly assigning the showers for each shift. Nursing will be in-serviced on accommodating a residents request for a shower, even if it is not their shower day. D. DON/designee will audit the POC CNA assignments daily X 5 days per week until three consecutive 100% compliance is achieved, weekly until three consecutive 100% compliance is achieved, monthly until three consecutive 100% compliance is achieved. Once we have achieved 3 months worth of 100% compliance, we will conclude that we have successfully addressed the deficient practice. Compliance rates will be reported in our QAPI meetings.	

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F 312	Continued From page 34 Manager). On 9/19/17 at 3:22 PM, during an interview with E6, she reviewed the shower schedule, and stated R13 was to have a shower on Monday and Thursday. E6 checked the CNA assignment list for showers for 9/18/17, and R13 was not on the list. E6 stated that upon review of the list, in error she wrote down the shower list for the 7:00 AM-3:00 PM shift, not the 3:00 PM-11:00 PM shift.. E6 stated staff was able to give showers to residents who are not on the list. The facility failed to ensure that a resident who was unable to carry out activities of daily living received the necessary assistance to shower. Findings were reviewed with E2 (DON) on 9/20/17 at 3:50 PM	F 312		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.	F 323		11/1/17

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F 323	Continued From page 35 (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, it was determined that the facility failed to ensure that the resident environment remained as free from accident hazards as was possible. Findings include: Surveyor observations on 9/12/17 were as follows: - at 10:58 AM, observed a loose safety bar next to the shared toilet in room 219; and - at 11:54 AM, observed an electrical outlet in disrepair in room 213. During an environmental tour on 9/19/17 from 3:08 PM to 3:10 PM, the findings above were observed and confirmed with E7 (FMD) and E8 (DOH). The facility failed to ensure the resident environment remained as free from accident hazards as was possible. Findings were reviewed with E1 (NHA) and E 2 (DON) during the exit conference on 9/21/17 at 7:30 PM.	F 323	A. The loose safety bar next to the shared toilet in room 219 was tightened immediately. B. Safety bars in resident bathrooms in each resident room were immediately inspected. No other safety bars were found to be loose. C. Toilet safety bars have been added to the Maintenance Director's Preventative maintenance tasks list. All staff will be in-serviced on submitting a maintenance request when observing a safety/disrepair issued in a resident room. D. Maintenance Director/designee will audit the toilet safety bars in 20 rooms per day daily X 5 days per week until three consecutive 100% compliance is achieved, weekly until three consecutive 100% compliance is achieved, monthly until three consecutive 100% compliance is achieved. Once we have achieved 3 months worth of 100% compliance, we will conclude that we have successfully addressed the deficient practice. Compliance rates will be reported in our	

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F 323	Continued From page 36	F 323	QAPI meetings. A. The electrical outlet cover in disrepair was replaced immediately. B. Electrical outlet covers in resident rooms were immediately inspected. No other electrical outlet covers were found. C. Electrical outlet covers have been added to the Maintenance Director's Preventative maintenance tasks list. Staff will be in-serviced on submitting a maintenance request when observing a safety/disrepair issue in a resident room. D. Maintenance Director/designee will audit the electrical outlet covers in 20 rooms per day daily X 5 days per week until three consecutive 100% compliance is achieved, weekly until three consecutive 100% compliance is achieved, monthly until three consecutive 100% compliance is achieved. Once we have achieved 3 months worth of 100% compliance, we will conclude that we have successfully addressed the deficient practice. Compliance rates will be reported in our QAPI meetings.	
F 329 SS=D	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug	F 329		11/1/17

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F 329	Continued From page 37 therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on clinical record review and interview, it was determined that the facility failed to monitor the effectiveness of Tylenol and consistently document the location of pain as per R16's care plan for one (R16) out of 33 Stage 2 sampled residents. Findings include:	F 329	A. Resident R16 will have their pain level documented post pain medication administration in the nurses note. B. Residents have had their records reviewed for accuracy of pain level	

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F 329	Continued From page 38 Review of R16's clinical record revealed the following: R16 was admitted to the facility on 8/18/17 and had a physician's order, dated 8/18/17, to receive Acetaminophen (Tylenol) 325 mg 2 tablets every 4 hours as needed for mild pain. The facility developed a care plan for R16, entitled potential for acute pain related to generalized pain, dated 8/18/17. Interventions included: "Monitor/record pain characteristics q (every) shift and PRN (as needed): Quality [e.g. sharp, burning]; Severity [1-10 scale]; Anatomical location...". For the pain scale, 0 (zero) would be no pain and 10 would be the worst possible pain). Review of MARs from 8/18/17 through 9/21/17 revealed that R16 received Tylenol on the following dates: 8/25/17, 8/29/17, 8/30/17, 9/3/17, 9/6/17, 9/12/17, 9/13/17, and 9/15/17. Review of R16's progress notes and MARs revealed that a post pain scale number (score) was only obtained after the 8/29/17 Tylenol administration. All other dates that R16 received Tylenol the post medication administration progress note stated it was effective, however, they lacked a post pain score. Review of progress notes and MARs additionally revealed that on 8/25/17, 9/6/17, and 9/15/17 the location of R16's pain was not documented prior to or after receiving Tylenol. During an interview with E2 (DON) on 9/21/17 at 3:26 PM, findings were reviewed and confirmed. E2 stated that the nurses were better at recording	F 329	documentation post med administration. C. Nurses will be in-serviced on documenting the pain scale in the nurses notes section after administration of a pain medication. D. DON/designee will audit the EMR to ensure pain levels pre and post pain med administration are documented daily X 5 days per week until three consecutive 100% compliance is achieved, weekly until three consecutive 100% compliance is achieved, monthly until three consecutive 100% compliance is achieved. Once we have achieved 3 months worth of 100% compliance, we will conclude that we have successfully addressed the deficient practice. Compliance rates will be reported in our QAPI meetings. A. Resident R16 will have their pain location documented in the nurses note. B. Residents have had their records reviewed for accuracy of pain location documentation. C. Nurses will be in-serviced on documenting the location of the pain in the nurses notes section after administration of a pain medication. D. DON/designee will audit the EMR to ensure location of the pain is documented in the nurses note daily X 5 days per week until three consecutive 100% compliance is achieved, weekly until three	

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F 329	Continued From page 39 pain locations and post pain scores before the facility switched to an electronic system.	F 329	consecutive 100% compliance is achieved, monthly until three consecutive 100% compliance is achieved. Once we have achieved 3 months worth of 100% compliance, we will conclude that we have successfully addressed the deficient practice. Compliance rates will be reported in our QAPI meetings.	
F 333 SS=E	483.45(f)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS 483.45(f) Medication Errors. The facility must ensure that its- (f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, interviews and review of other facility documents, it was determined that the facility failed to ensure that 2 (R16 and R116) out of 33 Stage 2 sampled residents were free of significant medication errors. The facility failed to ensure for R116 that Humulin R insulin was administered according to manufacturers specifications, specifically within 30 minutes before a meal or immediately after a meal. For R16, the facility failed to give Augmentin (antibiotic) per physician order for pneumonia. Findings include: The manufacturer's package insert (http://uspl.lilly.com/humulinru100/humulinru100.html) stated, "...PRECAUTIONS hypoglycemia...the most common adverse reaction of all insulin therapies...Severe hypoglycemia may lead to unconsciousness	F 333	A. R16 antibiotic order was clarified with her attending physician and administered as ordered. B. Residents receiving antibiotics were audited to confirm the orders were transcribed correctly and the medication administered per MD order. New anti-biotic orders will be reviewed during clinical meeting. C. Nurse who transcribed the ABT order was re-educated on properly transcribing physician order. D. DON/designee will audit resident MAR's who receive antibiotics daily X 5 days per week until three consecutive 100% compliance is achieved, weekly	11/1/17

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F 333	Continued From page 40 and/or convulsions and may result in temporary or permanent impairment of brain function or death...The timing of hypoglycemia usually reflects the time-action profile of the administered insulin formulations. Other factors such as changes in food intake (e.g., amount of food or timing of meals), injection site, exercise, and concomitant (given at same time) medications may also alter the risk of hypoglycemia...DOSAGE AND ADMINISTRATION:...is usually given three or more times daily before meals...The injection of Humulin R...should be followed by a meal within approximately 30 minutes of administration...". 1. Review of R116's clinical record revealed the following: 7/31/17 - R116 was admitted to the facility with diagnoses that included diabetes mellitus which required the administration of insulin for blood sugar control. 7/31/17 - A physician's order was written for R116 to have Humulin R SSI coverage dependant on Accu-Chek results that were to be completed before meals and at bedtime. Additionally, a physician's order also stated R116 was to receive Humulin R insulin 5 Units (U) twice a day. According to the dietary meal delivery schedule, breakfast trays were delivered to the 2nd floor, where R116 resided, at 7:10 AM and 7:30 AM (two meal carts were delivered). Review of eMARs from August 1, 2017 through September 20, 2017 revealed that the Humulin R 5 U was timed to be administered at 8:00 AM and	F 333	until three consecutive 100% compliance is achieved, monthly until three consecutive 100% compliance is achieved. Once we have achieved 3 months worth of 100% compliance, we will conclude that we have successfully addressed the deficient practice. Compliance rates will be reported in our QAPI meetings. A. R116 has received insulin properly since survey. Times were adjusted so that R116 receives Humulin R Insulin within 30 minutes of a meal. B. All residents who receive insulin before breakfast were audited for appropriate medication times and adjusted accordingly. Residents who receive a new order for insulin will be reviewed during clinical meeting. C. Nursing staff will be in-serviced on not administering insulin greater than 30 minutes before breakfast. D. DON/designee will audit resident MAR's who receive insulin before breakfast daily X 5 days per week until three consecutive 100% compliance is achieved, weekly until three consecutive 100% compliance is achieved, monthly until three consecutive 100% compliance is achieved. Once we have achieved 3 months worth of 100% compliance, we will conclude that we have successfully addressed the deficient practice. Compliance rates will be reported in our QAPI meetings.	

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F 333	Continued From page 41 5:00 PM. The eMARs also revealed that the Humulin R SSI coverage was timed to be administered at 6:30 AM, 11:30 AM, 4:30 PM, and 9:00 PM. Review of the eMARs revealed Humulin R SSI coverage signed off as administered on the following dates and times: - 8/5/17 6:30 AM - signed off administered at 6:37 AM; - 8/6/17 6:30 AM - signed off administered at 5:36 AM; - 8/7/17 6:30 AM - signed off administered at 5:32 AM; - 8/8/17 6:30 AM - signed off administered at 6:21 AM; - 8/9/17 6:30 AM - signed off administered at 5:41 AM; - 8/11/17 6:30 AM - signed off administered at 5:52 AM; - 8/12/17 6:30 AM - signed off administered at 5:51 AM; - 8/13/17 6:30 AM - signed off administered at 5:38 AM; - 8/14/17 6:30 AM - signed off administered at 5:41 AM; - 8/23/17 6:30 AM - signed off administered at 6:03 AM; - 8/27/17 6:30 AM - signed off administered at 5:37 AM; - 8/28/17 6:30 AM - signed off administered at 5:49 AM; - 9/11/17 6:30 AM - signed off administered at 5:51 AM; - 9/18/17 6:30 AM - signed off administered at 5:45 AM. The facility failed to ensure on the above listed occasions that R116 was administered Humulin R insulin within 30 minutes of breakfast creating the	F 333		

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F 333	Continued From page 42 potential for hypoglycemic episodes. The following observations/interviews were completed: 9/19/17 8:15 AM - R116 was observed seated in bed at a 90 degree angle eating breakfast; 9/20/17 8:23 AM - R116 was observed seated in a wheelchair in his room eating breakfast. 9/21/17 8:30 AM - During an interview, E17 (Unit Clerk) stated that breakfast usually arrives on the unit at 7:30 AM. 9/21/17 approximately 8:40 AM - During an interview, E18 (LPN) stated that breakfast usually arrives on the unit between 7-7:30 AM. During an interview on 9/21/17 at 11:30 AM, findings were reviewed with E2 (DON). Findings were reviewed during the exit conference on 9/21/17 at approximately 7:00 PM with E1 (NHA), and E2 [DON]. 2. Review of R16's electronic clinical record revealed the following: A progress note, dated 9/17/17 and timed 1:41 PM written by E15 (RN) stated that R16's chest x-ray revealed pneumonia and she received a new order (via telephone) from E16 (NP) for "Augmentin 875/125 mg q12 (every 12 hours) x (for) 5 days." Review of a care plan created on 9/18/17 for R16's pneumonia listed interventions including: administer medication as ordered and observe for possible side effects every shift. Review of the September 2017 MAR revealed	F 333		

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F 333	Continued From page 43 that R16's order stated, "Augmentin tablet 875-125 mg... Give 1 tablet by mouth every 12 hours every 5 day(s) for [L] (left) base minimal infiltrate (pneumonia) for 5 days" and a single dose was given on 9/18/17 at 9 PM. The progress note written by E15 stated the Augmentin should be given every 12 hours for 5 days, not one dose every 5 days. As of 9/21/17, R16 should have received 6 doses of Augmentin, not one. Review of the Order Summary Report revealed that E16's order was written incorrectly and was the same as it was on the MAR. During an interview with E2 (DON) on 9/21/17 at 3:26 PM, E2 confirmed that the order was put in wrong for R16's Augmentin and only one dose was given due to the order being put in incorrectly. E2 further stated, "This is a problem." The facility failed to be free of significant medication errors when R16 had Augmentin ordered on 9/17/17 to be given every 12 hours for 5 days for pneumonia. The order was put in the electronic system incorrectly which resulted in R16, as of 9/21/17, had only received one dose of Augmentin on 9/18/17 when she should have had 6 doses at this point in time.	F 333		
F 363 SS=D	483.60(c)(1)-(7) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED (c) Menus and nutritional adequacy. Menus must- (c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.;	F 363		11/1/17

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F 363	Continued From page 44 (c)(2) Be prepared in advance; (c)(3) Be followed; (c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; (c)(5) Be updated periodically; (c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and (c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observations, record review and interview, it was determined that the facility failed to follow the menu for one (R116) out of 33 Stage 2 sampled residents. Findings include: Review of R116's clinical record revealed the following: 8/25/17 - A physician's order was written for R116 to receive Super mashed potatoes (nutritionally enhanced) one time a day for increased intakes at lunch. 9/18/17 12:20 PM - Observed R116 seated in a wheelchair in the hallway feeding himself lunch. Observation of his lunch revealed that he had not been provided the super mashed potatoes with his lunch.	F 363	A. Unable to provide brussel sprouts and super mashed potatoes to R116 as the meal has already occurred. Tray tickets, including R116, are compared to what is on each tray and verified for accuracy prior to the trays leaving the kitchen and being served to the residents. B. Tray tickets have been reviewed for accuracy and updated accordingly. C. Dietary aids and cooks were immediately spoken to regarding tray accuracy. All dietary staff were in-serviced on 10/16/17 for tray accuracy. D. FSM/designee will audit the tray tickets and plates daily X 5 days per week until three consecutive 100% compliance is	

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F 363	Continued From page 45 9/19/17 12:22 PM - R116's meal ticket was observed for the midday meal. According to the meal ticket he was to receive sliced Brussels sprouts and pureed soup with his lunch. Neither item was observed on R116's lunch tray. 9/19/17 1:46 PM - During an interview, E20 (FSD) reviewed R116's lunch meal ticket and stated that yes, per the ticket, R116 should have received all the items listed. E20 stated that they have been trying different things with R116 to try to get him to eat more and that he has been refusing the pureed soups. The facility failed to consistently deliver food items listed on R116's meal ticket and items ordered by the physician. Findings were reviewed with E2 (DON) during an interview on 9/21/17 at approximately 11:30 AM.	F 363	achieved, weekly until three consecutive 100% compliance is achieved, monthly until three consecutive 100% compliance is achieved. Once we have achieved 3 months worth of 100% compliance, we will conclude that we have successfully addressed the deficient practice. Compliance rates will be reported in our QAPI meetings.	
F 371 SS=E	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.	F 371		11/1/17

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F 371	Continued From page 46 (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to ensure that the scoops for dry foods were protected from contamination and that resident food was properly maintained in safe refrigerated storage in the nourishment room of one out of two units reviewed. Findings include: 1. During the initial tour of the kitchen on 9/12/17 at 7:55 AM, three large bins containing dry foods, each with an open scoop holder attached on the outside, were observed to be in close proximity to a large trash container. The bin at one end also had a scoop in the scoop holder that was observed to be approximately 1/2 inch from the trash container. At 1:15 PM on 9/12/17, the trash container was observed to be less that one foot from the bins. On 9/18/17 at 9:45 AM, a follow-up visit to the kitchen found the three bins again in close proximity to the trash container. Two of the bins had their respective scoops in the open holders. Observations made on the closeness of the trash container to the bins were discussed with E20 (FSD) on 9/19/17 at 4:15 PM, who made immediate corrections to the situation.	F 371	A. The dry ingredients bin was immediately relocated to a more appropriate spot in the kitchen and the scoop was run through the dishwasher. The dry ingredients bin will no longer be stored near the trash can. B. Residents are not at risk for this deficient practice. C. Outside scoop holder was immediately removed. The FSD has added verifying proper placement of dry ingredient scoops to his opening and closing daily checklist. Dietary staff were in-serviced on 10/16/17 that the scoops to the dry ingredient bin are to be kept on the hook inside of the bin. D. The FSD will audit the dry ingredient bin daily X 5 days per week until three consecutive 100% compliance is achieved, weekly until three consecutive 100% compliance is achieved, monthly until three consecutive 100% compliance is achieved. Once we have achieved 3 months worth of 100% compliance, we will conclude that we have successfully	

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REGENCY HEALTHCARE & REHAB CENTER	801 N. BROOM STREET WILMINGTON, DE 19806

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F 371	Continued From page 47 2. A visit to the nourishment room on the second floor on 9/19/17 at 2:15 PM found unidentified liquids in two tall disposable cups in the refrigerator, without label and date. This finding was reviewed with E20 on 9/21/17 at 2:45 PM. 3. Review of the year-to-date temperature logs for the second floor nourishment room revealed the number of days with missing temperatures for the following months: January: 15 days March: 10 days April: 9 days May: 19 days June: 7 days July: 10 days August: 5 days In an interview on 9/20/17 at 3:45 PM, E3 (ADON) stated that the facility was developing a policy and procedure on recording refrigerator temperatures on the two units to ensure that temperatures were recorded daily. Findings were reviewed with E1 (NHA) and E2 (DON) on 9/21/17 at 7:30 PM.	F 371	addressed the deficient practice. Compliance rates will be reported in our QAPI meetings. A. Tall disposable cups located in the refrigerator in the second floor unlabeled and undated were immediately disposed of. B. No residents were adversely affected by this deficient practice. C. Staff to be in-serviced on need to label and date all resident food placed into the refrigerator. Housekeeping and nursing will check the refrigerator daily. Any unlabeled and/or undated food containers will be immediately discarded. If the food is labeled and dated. it will be discarded after 3 days. D. DON/Housekeeping/designee will audit the refrigerator for unlabeled and/or undated food containers daily X 5 days per week until three consecutive 100% compliance is achieved, weekly until three consecutive 100% compliance is achieved, monthly until three consecutive 100% compliance is achieved. Once we have achieved 3 months worth of 100% compliance, we will conclude that we have successfully addressed the deficient practice. Compliance rates will be reported in our QAPI meetings. A. Refrigerator temps are being recorded daily since survey. Unable to go back and document refrigerator temps as they are	

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F 371	Continued From page 48	F 371	unknown. B. No residents were affected by this deficient practice. C. Nursing staff will be in-serviced on documenting the refrigerator temps in the nourishment rooms and med rooms daily. D. DON/designee will audit the refrigerator temp logs daily X 5 days per week until three consecutive 100% compliance is achieved, weekly until three consecutive 100% compliance is achieved, monthly until three consecutive 100% compliance is achieved. Once we have achieved 3 months worth of 100% compliance, we will conclude that we have successfully addressed the deficient practice. Compliance rates will be reported in our QAPI meetings.	
F 412 SS=D	483.55(b)(1)(2)(5) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS (b) Nursing Facilities The facility- (b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services;	F 412		11/1/17

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F 412	Continued From page 49 (b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; (b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined that the facility failed to ensure that dental services were obtained for one (R13) out of 33 Stage 2 sampled residents. Findings include: Review of R13's records and staff and resident interviews revealed: 2/2/17 - A nurse's progress note stated, 'Received new order for dental consult." 2/10/17 - A dental consult was completed and stated that R13 had an abscess and the recommendation was to transport to the dental office for extraction (removal) of the tooth. Observations of R13 during on 9/12/17 at 2:40 PM, 9/13/17 at 4:10 PM, and 9/14/17 at 9:30 AM, revealed that she had missing teeth. R13 was interviewed on 9/12/17 at 2:53 PM. R13 stated she had "two big cavities right and left lower molars and has had cavities about one year." R13 stated she last saw a dentist "a long	F 412	A. Resident R13 does not want any further tooth extractions stating "I don't have many teeth left already". B. Residents who were seen by the dentist were audited to ensure recommendations were followed up on and appointments made accordingly. C. Social Services will inquire whether a resident would like assistance with arranging dental services upon admission. If a resident inquires about receiving assistance with arranging dental services, social services will assist with arranging the appointment as well as transportation if the resident needs to be seen in an office in lieu of in the facility. Social Services will follow up on a quarterly/as needed basis and will document in the residents chart. Social Services and nursing will be in-serviced on proper follow up with dental recommendations.	

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F 412	Continued From page 50 time ago." R13 was interviewed on 9/14/17 at 9:30 AM. R13 stated "a while ago she thought she had an earache and told the nurse." R13 stated a dentist came to see her, but no treatment was done. R13 stated she has not seen a dentist since that time. E3 (ADON) was interviewed on 9/14/17 at 3:50 PM regarding the process for dental services. E3 stated Social Services makes all arrangements for routine and emergency dental services. E4 (Social Services) was interviewed on 9/14/17 at 4:05 PM regarding the process for dental services. E4 stated she sends referrals for urgent care to a dental office. E4 stated the dentist will see residents at the facility, but if they need work done on their teeth he will see the resident at his dental office. E4 stated that if a resident needs to be seen at the dental office, she would make the arrangements for the resident to go to the dental office. E4 was unable to find documentation that R13 had been seen at the dental office per the recommendation of the dental consult dated 2/10/17, For 7 months the facility failed to follow through with the consultant dentist's recommendation that R13 be transported to the dental office for a tooth extraction. Findings were reviewed and confirmed with E2 (DON) on 9/20/17 at 3:45 PM.	F 412	D. SSD/designee will audit the dental consults daily X 5 days per week until three consecutive 100% compliance is achieved, weekly until three consecutive 100% compliance is achieved, monthly until three consecutive 100% compliance is achieved. Once we have achieved 3 months worth of 100% compliance, we will conclude that we have successfully addressed the deficient practice. Compliance rates will be reported in our QAPI meetings.	
F 428 SS=D	483.45(c)(1)(3)-(5) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON	F 428		11/1/17

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F 428	Continued From page 51 c) Drug Regimen Review (1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. (3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. (4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending	F 428		

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F 428	Continued From page 52 physician should document his or her rationale in the resident's medical record. (5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to have MRRs (Medication Regimen Reviews) completed by a consultant pharmacist and/or have evidence that pharmacy recommendations were communicated to the physician and DON for consideration and subsequent responses for three (R90, R100 and R116) out of 33 stage 2 residents. Findings include: 1. Review of R100's clinical record revealed: The MRRs for R100 were completed by the consultant pharmacist from November 2016 through January 2017 and March 2017 through August 2017. The facility failed to provide evidence that R100's monthly MRR was completed in February 2017. Review of the consultant pharmacists MRR sheets revealed there were physician recommendations on the following dates: 12/27/16, 3/24/17, 4/26/17, and 5/22/17. Review of the clinical record lacked evidence that the recommendations from 3/24/17 and 4/26/17	F 428	A. Pharmacy reviews have been completed every month prior to February 2017 and beginning March 2017. R100, unable to go back and obtain missing pharmacy consultant as we did not have a consultant in the month of February 2017. Pharmacy recommendations from 03/24/17 and 04/26/17 for R100 have been reviewed and updated accordingly. B. Resident charts were audited to ensure we did not miss a necessary recommendation in February 2017. C. Unit Managers and RN Supervisors will be in-serviced on the pharmacy consultant coming in on a monthly basis. D. DON/designee will audit the pharmacy consultant monthly until three consecutive 100% compliance is achieved, Once we have achieved 3 months worth of 100% compliance, we will conclude that we have successfully addressed the deficient practice. Compliance rates will be reported in our QAPI meetings.	

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F 428	Continued From page 53 were communicated to the physician and/or DON for consideration and subsequent responses. During an interview on 9/20/17 at 3:31 PM, E2 (DON) stated that she could not find evidence showing the MRR recommendations for R100 on 3/24/17 and 4/26/17 were reviewed. E2 confirmed there was no evidence of a MRR in February 2017 due to the facility not having a consultant pharmacist at that time. 2. Review of R116's clinical record revealed: The MRR was completed by the consultant pharmacist for August 2017. Review of the August 2017 consultant pharmacist's recommendation summary revealed there was a physician recommendation for R116. R116's clinical record lacked evidence that the August 2017 recommendation was submitted to the physician for consideration and subsequent response. The facility failed to act upon a consultant pharmacist recommendation for R116 in August 2017. During an interview on 9/20/17 at 2:40 PM, E2 (DON) was informed of the lack of R116's pharmacy recommendation from August 2017. On 9/20/17 at 3:30 PM, E2 stated they were unable to find the recommendation but were still looking. 3. Review of R90's clinical record revealed the following:	F 428	A. R116 pharmacy recommendations have been followed since survey. Prior recommendations were reviewed by the physician and updated accordingly, including August 2017. B. All residents are at risk for this deficient practice. C. Nursing will be in-serviced on ensuring pharmacy recommendations are followed up on by the attending physician in a timely manner, no greater than 30 days from the recommendation. D. DON/designee will audit the pharmacy recommendations daily X 5 days per week until three consecutive 100% compliance is achieved, weekly until three consecutive 100% compliance is achieved, monthly until three consecutive 100% compliance is achieved. Once we have achieved 3 months worth of 100% compliance, we will conclude that we have successfully addressed the deficient practice. Compliance rates will be reported in our QAPI meetings. A. R90 unable to go back for pharmacy review as this was missed in February. R90 has had a pharmacy review every month prior to and after February 2017. Any recommendations have been followed up on accordingly. B. All residents are at risk for this deficient practice. C. Unit Managers and RN Supervisors	

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F 428	Continued From page 54 Review of R90's MRRs revealed they were completed in December 2016, January 2017, and from March- August 2017. There was no evidence that a MRR was completed by a consultant pharmacist in February 2017. Findings were reviewed with E1 (NHA) during an interview on 9/20/17 at 3 PM. E1 stated the facility got a new consultant pharmacist in February 2017, however, he was backlogged and unable to do reviews until March 2017. The facility failed to have a monthly MRR completed by a consultant pharmacist for R90 in February 2017.	F 428	will be in-serviced on the pharmacy consultant coming in on a monthly basis. D. DON/designee will audit the pharmacy consultant coming into the facility monthly until three consecutive 100% compliance is achieved. Once we have achieved 3 months worth of 100% compliance, we will conclude that we have successfully addressed the deficient practice. Compliance rates will be reported in our QAPI meetings.	
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to:	F 441		11/1/17

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F 441	Continued From page 55 (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 441		

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F 441	Continued From page 56 (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and review of facility policy and procedure, it was determined that the facility failed to ensure that PPD testing (Protein Purified Derivative, skin test to screen for tuberculosis, a contagious infection that usually attacks the lungs) was completed upon admission for one (R116) out of 5 sampled residents. Findings include: The facility policy and procedure regarding PPD (Protein Purified Derivative) testing, revision date 2016, stated, "...the two-step PPD test will be used to establish a baseline will be followed for all new admissions to the facility...". R116 was admitted to the facility on 7/31/17 post hospitalization. Review of the eMAR, eTAR, progress notes and physician's orders from 7/31/17 through 9/17/17 revealed a lack of evidence that a two-step PPD skin test was completed for R116 upon admission to the facility. During an interview on 9/14/17 at 4:15 PM, E3 (ADON) stated any resident coming in to the facility from the hospital and/or community get a two-step PPD skin test completed. This surveyor informed E3 that the clinical record lacked evidence of a completed two-step PPD for R116. E3 stated she would look into it . On 9/18/17 at 8:09 AM, during a second interview	F 441	A. A chest x-ray was completed for R116 shortly after admission confirming no active disease. B. New admissions were audited to ensure 2-step ppd's have been administered or a chest x-ray obtained to rule out active disease. C. Nursing staff to be in-serviced on entering and scheduling 2 step ppd for all new admissions in the EMAR system. D. DON/designee will audit the new admission charts for accurate endtry of ppd order daily X 5 days per week until three consecutive 100% compliance is achieved, weekly until three consecutive 100% compliance is achieved, monthly until three consecutive 100% compliance is achieved. Once we have achieved 3 months worth of 100% compliance, we will conclude that we have successfully addressed the deficient practice. Compliance rates will be reported in our QAPI meetings.	

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F 441	Continued From page 57 with E3 confirmed that the two-step PPD for R116 "was missed." The facility failed to ensure that PPD testing was completed upon admission for R116. Findings were reveiwed with E2 (DON) during an interview on 9/21/17 at approximately 11:30 AM.	F 441		
F 514 SS=D	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;	F 514		11/1/17

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F 514	Continued From page 58 (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to have accurately documented progress notes by nursing staff for one (R16) out of 33 Stage 2 sampled residents related to the resident's Augmentin (antibiotic). Findings include: Cross refer to F333, example #2 Review of R16's clinical record revealed; A progress note, dated 9/17/17 and timed 1:41 PM written by E15 (RN) stated that R16's chest x-ray revealed pneumonia and she received a new order (via telephone) from E16 (NP) for "Augmentin 875/125 mg q12 (every 12 hours) x (for) 5 days." Review of the September 2017 MAR revealed that R16's order stated, "Augmentin tablet 875-125 mg... Give 1 tablet by mouth every 12 hours every 5 day(s) for [L] (left) base minimal infiltrate (pneumonia) for 5 days" and a single dose was given on 9/18/17 at 9 PM. The progress note written by E15 stated the Augmentin should be given every 12 hours for 5 days, not one dose every 5 days. As of 9/21/17, R16 should have received 6 doses of Augmentin, not one. Although staff only gave one dose of Augmentin to R16 on 9/18/17 and she did not receive any on 9/20- 9/21/17 (5 doses), the following progress notes were written by nursing staff:	F 514	A. R16 antibiotic order was clarified by the attending physician. R16 received her antibiotic per physicians order. B. Residents currently receiving antibiotics were audited to ensure their orders were properly transcribed. C. All nurses will be in-serviced on proper transcription of a physicians order. D. DON/designee will audit newly ordered antibiotics daily X 5 days per week until three consecutive 100% compliance is achieved, weekly until three consecutive 100% compliance is achieved, monthly until three consecutive 100% compliance is achieved. Once we have achieved 3 months worth of 100% compliance, we will conclude that we have successfully addressed the deficient practice. Compliance rates will be reported in our QAPI meetings.	

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F 514	Continued From page 59 9/19/17 (2:35 PM)- "...On ABT therapy for PNA, no adverse reaction noted." 9/19/17 (11:47 PM)- "...On ABT therapy for PNA, no adverse reaction noted....". 9/20/17 (6:46 AM)- "...continues ABT therapy, no adverse reaction...". 9/20/17 (3:40 PM)- "...continues on abt Augmentin...No adverse reactions noted...". 9/20/17 (11:21 PM)- "...Continues with antibiotics for PNA...". 9/21/17 (6:49 AM)- "...continues abt therapy, no adverse reaction...". During an interview with E2 (DON) on 9/21/17 at 3:26 PM, findings were reviewed and confirmed. The facility failed to have accurate progress notes by nursing when R16 incorrectly received a single dose of oral Augmentin on 9/18/17, when she should have had the medication every 12 hours for 5 days. After the dose of ABT was given, staff continued to chart that the ABT was ongoing and that there were no side effects from the Augmentin.	F 514		

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: Regency Healthcare and Rehab Center **DATE SURVEY COMPLETED: September 21, 2017**

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by references and also cites the findings specified in the Federal Report. An unannounced annual and complaint survey was conducted at this facility from September 12, 2017 through September 21, 2017. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census the first day of the survey was 89. The Stage 2 survey sample size was 33.	Regency Healthcare did not make PPD on 9/3/17 due to excessive call outs and not having staff willing to come in due to the holiday. Staff who called out were all spoken to regarding their call out and the need to be here for the residents. No residents were impacted by this one day of not making PPD. Regency has made or exceeded the PPD every day before and after 9/3/17. The Scheduler is responsible for ensuring we have enough staffing on the schedule to meet the PPD. The DON oversees this process. The PPD is discussed daily in morning meeting. If we are not making PPD, immediate phone calls are made and the nurse management team	11/13/17
3201	**Regulations for skilled and intermediate care facilities**		
3201.1	**Scope**		
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:** Cross Refer to the CMS 2567-L survey completed on September 21, 2017: F225, F226, F241, F248, F253, F280, F309, F312, F323, F329, F333, F363, F371, F412, F428, F441 & F514.		

Provider's Signature T O'Connell Title NHA Date 10/13/17

NAME OF FACILITY: Regency Healthcare and Rehab Center DATE SURVEY COMPLETED: September 21, 2017

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	16 Del. C., 1162 Nursing Staffing: (c) By January 1, 2002, the minimum staffing level for nursing services direct caregivers shall not be less than the staffing level required to provide 3.28 hours of direct care per resident per day, subject to Commission recommendation and provided that funds have been appropriated for 3.28 hours of direct care per resident for Medicaid eligible reimbursement. Nursing staff must be distributed in order to meet the following minimum weekly shift ratios: RN/LPN CNA* Day 1 nurse per 15 res. 1 aide per 8 res. Evening 1:23 1:10 Night 1:40 1:20 * or RN, LPN, or NAIT serving as a CNA. (g) The time period for review and determining compliance with the staffing ratios under this chapter shall be one (1) week. ..... Facility staffing reviews were conducted for the following three (3) week periods: 4 June 2017 through 10 June 2017 2 July 2017 through 8 July 2017 3 September 2017 through 9 September 2017 These activities occurred in order to verify compliance with Delaware Nursing Home Staffing Laws, commonly known as Eagles' Law. The review consisted of data entered on the DLTCRP Staffing Worksheets by Regency Healthcare and signed by the Administrator. The **ONE (1)** citation hereon results from that work.	go to the floors to ensure resident care and assist the CNA's. If a call out occurs during an off shift, the Supervisor recalculates the PPD. If we will not make PPD due to the call out, the Supervisor notifies the DON and makes phone calls to all of the staff until one agrees to come in for that shift. The DON and NHA review the PPD daily. We will document on the audit tool our daily compliance for 3 weeks or until we achieve 100% compliance, daily for 2 weeks or until we achieve 100% compliance, daily for 1 week or until we achieve 100% compliance. After reviewing the PPD daily, one month later, if continue to be 100% compliant, we will assume we have successfully addressed the deficiency.	11/13/17

Provider's Signature TDConnell Title NHA Date 10/13/17

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SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The law was not met as evidenced by: Regency failed to meet the required 3.28 Daily Care Hours per Resident mathematical minimum on the following **ONE (1)** date. The care hours attained by the provider on the day are parenthesed. 1. Sunday, 3 September 2017 (3.16).		

Provider's Signature T Connell Title NHA Date 10/13/17